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Authors

Minkler, Meredith
Rebanal, R David
Pearce, Robin
et al.

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Growing Equity and Health Equity in Perilous Times: Lessons From Community Organizers

Meredith Minkler, DrPH, MPH[1], R. David Rebanal, DrPH, MPH[2], Robin Pearce, MPH[1], and Maria Acosta, MPH[2]

Abstract

Although a growing body of evidence underscores the contributions of community-based participatory research, community coalitions and other community engagement approaches to addressing health equity, one of the most potent forms of engagement—community organizing—has attracted far less attention in our field. Yet, organizing by and for communities, to build power, select issues, develop and use strategies, and take action to address the goals they collectively have set, may offer important lessons for public health professionals in these fraught times. We share, largely in their own words, the experiences and reflections of ~140 grassroots organizers across the United States who attended regional convenings of organizers in 2017, planned and run by four leading community capacity and base-building organizations, and where diverse organizers shared strategies that work, challenges faced, and the deep concerns among their already often disenfranchised communities in the contemporary sociopolitical and cultural context. After briefly reviewing some of community organizing's core tenets and complexities, we share our qualitative research methods and key findings about the primary cross-regional concerns raised (mass incarceration, voter suppression, and immigrant rights), the themes that emerged (e.g., centering leadership by women of color and of using a health lens to frame community issues), as well as the challenges faced (e.g., the retraumatization often experienced by organizers and the difficulties in building alliances between groups "that have been taught to distrust each other"). We conclude by discussing how many of the promising practices and lessons shared by the community organizers might enhance our own field's health equity-focused efforts, particularly if we take seriously one of their most bedrock messages: that there can be no health equity without racial equity and social justice, and that to get to health equity, we must first address equity writ large, particularly in troubling times.

Keywords

African American, community health, LGBTQ, qualitative methods

> Organizing teaches, as nothing else does, the beauty and strength of everyday people.
>
> —Barack Obama (1988)

Over the past 40 years, public health professionals have increasingly recognized the imperative of working "*with* rather than on communities" to improve health and reduce health inequities. In Ross' (2016) words, "the path to health equity and healing *begins* with participation in the process," which, indeed, is "the engine that drives" the entire effort (p. 1, italics added).

A robust evidence base nationally and globally underscores the potent role of community engagement and empowerment in improving the public's health (Cyril, Smith, Possamai-Inesedy, & Renzaho, 2015; Milton et al., 2012; O'Mara-Eves et al., 2015; Rifkin, 2014; Wallerstein, 2006). Increasingly, moreover, this research has documented the contributions of engaged communities in advocating for and helping effect change in the physical, social, and policy environments in which health behavior and decision making take place (Brown, Morello-Frosch, & Zavestoski, 2011; Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014; Iton & Shrimali, 2016; Minkler, Garcia, Rubin, & Wallerstein, 2012). Community engagement thus has been a key contributor to health equity-focused policy changes promoting cleaner air, safe water, safe spaces for physical activity, and access to

[1]University of California, Berkeley, CA, USA
[2]San Francisco State University, San Francisco, CA, USA

Corresponding Author:
Meredith Minkler, School of Public Health, University of California, 140 Warren Hall, Berkeley, CA 94720-7360, USA.
Email: mink@berkeley.edu

healthy foods and transportation in low-income communities (Brown et al., 2011).

Numerous studies, including randomized controlled trials and systematic reviews, have documented promising processes and outcomes of community-based participatory research, coalition building and other community engagement approaches in public health (Butterfoss & Kegler, 2012; De las Nueces, Hacker, DiGirolamo, & Hicks, 2012; Kagawa-Singer, Dressler, George, & Elwood, 2015; Wallerstein, Duran, Oetzel, & Minkler, 2018). Yet far less attention has been paid to what is arguably the highest level of community engagement: organizing by and for communities themselves to build power, identify common problems, and develop and use strategies for action to achieve the change they seek. As public health's focus has evolved from rediscovering and emphasizing, two decades ago, the field's deep roots in the social determinants of health (SDoH; Krech, 2012; Virchow, 1848/1985), to understanding the health and equity impacts of all policies, to now working intentionally to understand and address systems of oppression rooted in racism, classism and heterosexism, and other "isms," so too must the field's community engagement strategies move to more deeply embrace community leadership and control through community organizing.

There is much public health professionals can learn from organizing, whether about improving the effectiveness of our own community-engaged coalitions or being better allies to communities in their equity-focused change efforts (Butterfoss & Kegler, 2012; Wolff et al., 2017). Indeed, community organizing is one of Wolff et al.'s (2017) six principles for Collaborating for Equity and Justice. As they note "a weakness in most community-based coalitions, collaboratives and partnerships is the absence of community organizing [which] creates the power necessary to demand and share in decision making" (p. 45). Furthermore, grassroots organizers, and the base—building, empowerment, advocacy, and other skills they bring to the table, may be particularly critical to engaging marginalized and otherwise hard-to-reach populations.

In 2016, as part of its efforts to help build a *Culture of Health*, "ensuring opportunities that provide everyone a chance to live the healthiest possible life now and in generations to come" (Plough, 2017, p. 1; see also Plough & Ford, 2015), the nation's largest health philanthropy, the Robert Wood Johnson Foundation, funded four leading grassroots base-building organizations to conduct regional convenings of community organizers around the country. Held between March and July 2017, the convenings enabled Robert Wood Johnson Foundation to "learn from experts" about strategies that might be useful in its own Culture of Health efforts. In addition, the multiday events provided a space for diverse grassroots organizers to share their issues, achievements and challenges and further their own collaborations during a time of political upheaval, unprecedented economic inequalities, and daily threats to civil and human rights (Blackwell, 2018; Reich, 2018).

Our research team was tasked with capturing and analyzing extensive qualitative data from the convenings and disseminating findings to the Foundation, as well as to public health practitioners, researchers, and other funders, with implications on how they might better understand and support the work of grassroots organizers while applying organizers' lessons to our own health equity-focused work. Elsewhere we discuss findings relevant to health equity-focused philanthropies (Acosta, 2018; Pearce, 2018; Rebanal, 2018). Here, however, we share our findings and analysis related to three research questions of special relevance to health educators and other public health professionals:

Research Question 1: What community organizing strategies and approaches are being used to build power among marginalized and other vulnerable groups and communities?

Research Question 2: What challenges and barriers are organizers and their communities facing, particularly in the contemporary sociopolitical and cultural context of the United States?

Research Question 3: What community organizing approaches and practices can enhance current and emerging public health strategies to achieve health equity?

Community Organizing: Some Tenets and Complexities and Their Relevance for Equity and Health Equity

Community organizing is a process by which communities identify their assets and concerns, prioritize and select issues, and intentionally build power and develop and implement action strategies for change (Minkler, 2012; Staples, 2012, 2016; Wolff et al., 2017). Reflected in this definition, organizing tenets frequently include empowerment, starting with issues that matter to the people, community capacity building, issue selection, and using a variety of strategies to affect change. Yet no one set of tenets captures the complexity of community organizing, nor the breadth and depth of thinking and approaches encompassed by this term. Rather, organizing efforts reflect such factors as the conceptual orientation(s) of the organizers, the organizations with which they're working (e.g., immigrant and refugee associations, unions, or faith-based coalitions) and the historical, sociocultural, and community contexts in which the organizing takes place. DeFilippis, Fisher, and Shragge (2010) thus write about the "deliberate pragmatism" in organizing during the Great Recession, with an accent on narrow and immediate community concerns, and less attention to broader economic and social justice issues. Fast forward to the U.S. 2016 presidential election and its aftermath, however, and a far greater accent on social justice is seen in local organizing, as well as stronger linkages with regional, national, and global organizing to address issues from human trafficking to climate change, with increasing demands for government accountability.

In health education and public health more broadly, growing interest in community organizing approaches to equity and health equity have stressed the importance of systems change with a focus on the SDoH. Indeed, as Braveman, Arkin, Orleans, Proctor, and Plough (2017) note, getting to health equity "*requires* removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (p. 2, italics added). Removing such barriers to equity is often a major part of both grassroots organizers' and public health professionals' raison d'etre.

In the United States, community organizing has deep roots in early efforts to redress power imbalances between "haves" and "have nots," typically, though not always, based on race/ethnicity and social class (Alinsky, 1972; Sen, 2003; Staples, 2016). Yet many organizers went further to understand and address structural and institutionalized racism and inequities in power and privilege, including, especially in more recent decades, inequities along such dimensions as sexual orientation and gender identity, immigration status, age, and ability/disability (DeFilippis et al., 2010; Martinson & Su, 2012). Finally, and while equity was intentionally infused into some community organizing processes in the past, many of today's organizers are deeply attentive to equity and social justice, not solely as *outcomes* of the work but also as vital to the very *process* of organizing, including equitable involvement in decision making that affects the lives of people and their communities (Minkler, 2010). This deeper focus on process can further promote critical consciousness among a wider network of community members and grassroots organizers, health professionals, and others necessary for sustaining social movements (Brown et al., 2011).

Method

Research Paradigm

Like most qualitative research, the conceptual frame for this study involves an interpretive perspective which "sees the world as constructed, interpreted and experienced by people in their interactions with each other and with wider social systems" (Ulin, Robinson, & Tolley, 2012, pp. 17-18).

Sample

Community organizers were identified and invited to take part in one of four regional convenings by a leading base-building organization: Praxis Project in the West, the Center for Community Change in the Midwest, PICO National Network in the South, and the Center for Popular Democracy in the Northeast. These organizations, which also facilitated the convenings in their respective areas, invited individuals they considered leading equity-focused organizers in their regions.

A total of 137 organizers, ranging in age from their 20s to their 70s comprised the final sample. Variation in sample composition by region was roughly 70% African American, 15% European American, 10% Latino, and 5% Asian Pacific Islanders (API) in the South; 45% each African American and European American with 10% Latino in the Midwest; ~65% European American with the remainder roughly evenly divided between African Americans, Latinos, and API; and in the West, 46% Latino, 23% African American, 15% each API and Indigenous people, and 1% European American. Several rural organizers were present at each convening, but most participants worked in low-income urban areas. Although sexual orientation and gender identity were only self-disclosed as desired, several members brought up being lesbian and/or transgender as it related to issues of stigma, access to care and other issues.

Data Collection

Two members of the research team attended each 3-day regional convening and obtained written informed consent from participants in accordance with University of California Berkeley's Committee for the Protection of Human Subjects. Team members took extensive notes and audio recorded all large sessions and additional small group sessions, where feasible, the latter using table microphones. Our audio recording capacity for some small groups was constrained by background noise; in both the West and Northeast regions, however, each small group shared highlights of its discussions with the full convening and these remarks were fully captured.

Recordings were professionally transcribed, and both they and the researchers' notes were shared with all team members for initial review. A team discussion followed on data quality, initial impressions, and insights about how the findings aligned with our research questions, as well as preliminary codes that "jumped out." A codebook was developed iteratively through a collaborative, multistep process based on our research questions, the data themselves, and the extant literature (DeCuir-Gunby, Marshall, & McCulloch, 2011). Consistent with Ulin et al. (2012) and the Standards for Reporting Qualitative Research Guidelines (O'Brien, Harris, Beckman, Reed, & Cook, 2014), we began with nine deductive codes (those predetermined by our research questions or derived from earlier research). Among these were strategies for base-building, engaging informal leaders, identifying winnable issues, and challenges faced in community organizing. Thirteen inductive codes (those that emerged from the data during the process of coding) also were included, among them racial and other systems of oppression, unique challenges to women of color-led organizing, rural–urban divides, coping with trauma, and the utility of using a health lens in framing community concerns. The initial codebook was uploaded to an online software program for qualitative data management (Dedoose version 7.6.18), which enabled each researcher to add new codes as they emerged. Transcripts for each site were double coded, with coding teams then flagging, discussing, and reconciling any discrepancies. Although

no formal calculation of interrater reliability was made, there was strong agreement on the great majority of coding within teams with reconciliation of any differences made typically through a discussion of the rationale for our independent coding decisions. All four researchers then participated in identifying cross-site themes and flagging any additional findings of relevance to our research questions.

Findings

Four, often intersecting themes emerged from the data across all sites: (a) starting with the community's issues, (b) engaging neglected or disenfranchised communities to build leadership and power, (c) centering organizing led by women of color, and (d) leveraging public health and "using a health lens" in framing community issues.

Starting With Issues That Matter to the Community

Organizers in all regions articulated the importance of starting with issues that are deeply felt, by the community. They further stressed that these issues typically do not fall under a narrow health rubric, and that if public health professionals want to get to health equity, we must start with more fundamental issues of race-based oppression and social injustice. As a Midwestern organizer noted,

> . . . The only way we can address [health equity] and create a Culture of Health . . . is to address the issues of racial equity, to address the issues of systemic oppression, to address the fact that we might not make the clinic appointment because immigration [agents] might be sitting outside so it's not safe for us to leave the house. If we don't address all of that, we can't really address health equity or any [Culture of Health].

In the South, an organizer put health equity in historical context, stating,

> At this point, if we talk about equity, we need to be talking about righting the wrongs, and how we aggressively and proactively seek to heal, literally, our communities medically and give the extra attention that we've been denied for generations, so that we can come anywhere close to being at the same level. To me, that has to be a starting point.

Three primary and sometimes overlapping issues surfaced across all four regions which had become a major focus of the organizers' work. These were as follows:

> (1) *Mass incarceration*, particularly as it affects the social and economic well-being of men of color and their communities. As an organizer in the Northeast remarked, "The fact that we've invested all these resources to lock people up, it has had a repercussion in [African American and Latino] communities." Others shared the statistics, e.g., that in recent years close to a third of African American men in America were incarcerated, on parole, or on probation taking an incalculable toll on the individual, family, community and societal levels.
>
> (2) *Voter suppression*, especially in the South where as one organizer noted, "You have lots of people engaged—from the faith community to unions, [and] immigrants—organizing a ground game, but [they] are swimming in a sea of red without votes." For organizers with "Faith in Florida," this meant working with allies to garner support for an (ultimately successful) ballot measure to restore the voting rights of 1.4 million overwhelmingly African Ameican and Latino residents who had been banned for life from voting after serving time for a felony conviction.
>
> (3) *Protecting and promoting immigrant rights*, or "making sure the voices of refugees and immigrants are lifted up and brought to the table, in terms of organizing and the resistance that they are waging." In both the West and the South, organizers remarked about the complexity of this issue, whereby long-time residents of color sometimes worry that a large influx of new immigrants dilutes their strength and draws public and policy maker attention from their own unmet needs. But in each region, working among and with immigrants to protect their rights was a far more central concern, though sometimes with a call for broader dialogue to support established as well as newer population groups. As an organizer from the Midwest pointed out, "Quick, kneejerk solutions, I think, lead to sanctuary cities for immigrants . . . but there's no sanctuary in the Black community."

In addition to the three core issues above, three, more traditional health issues were discussed, albeit not in as much detail, particularly in the Northeast. These were as follows: *mental health stigma and treatment*, particularly for already stigmatized groups, lack of health care access for the undocumented, and *the opioid epidemic*. Yet even when these issues were discussed, the organizers contextualized them within the current sociopolitical and cultural climate and historically, rooted in deep seeded forms of systemic oppression. In discussing lack of health care access for immigrant Latinos, for example, a Midwestern organizer remarked, "Obviously, the primary concerns for immigrants are: 'Do I have a job? Do I have [enough money] to be able to provide for my family? *Am I going to be deported today?*'"

Similarly, when talking about the opioid epidemic exacting a heavy toll in rural and urban communities alike, two African American organizers spoke with passion about the very different ways in which the (largely European American) communities affected by the current opioid epidemic were being named and treated, compared with the (largely African American) communities caught up in the crack cocaine epidemic in the 1980s. As one remarked,

> *Now* you want a public health approach because it's White kids and White families that are being impacted. But when it was us, it was "lock them up and throw away the key," and let's invest

> as much money as we can into the system of maximum incarceration that's going to put us behind cages. (Northeastern Organizer)

As these and other organizers pointed out, unless health and social problems are contextualized historically, sociopolitically, and culturally, progress toward addressing them will likely have only limited success.

Engaging Neglected, Disenfranchised Communities to Build Leadership and Power

In each region, organizers shared numerous examples of successful approaches and strategies used to increase community capacity and power while working on issues that mattered locally. These ranged from a listening tour of 30 cities in NY State to door-knocking in rural communities, to skill building in leadership, and advocacy in the West. As an organizer working with immigrant agricultural workers reported,

> [We teach them] a cycle of advocacy that allows them to identify the issues [and then find] a solution that they want to see happen, and work at building alliances and partnerships among their comrades, compadres, neighbors—all of this, to create that power . . .

Whether rural residents, LGBTQ (lesbian, gay, bisexual, transgender, and queer) people, the incarcerated and their families, or immigrants and refugees, many organizers spoke of the need to "show up" and engage communities, especially those that were forgotten or disenfranchised. As a Midwestern rural organizer remarked, "[We build leadership] in populations that most would think are un-organizable. I think the thing we've learned is that's not true." The imperative of focusing on organizing with and by youth also was stressed, with a Southern organizer commenting, "[We need] young people not just *in* the movement we're building but *leading* the movement."

Across regions, participants emphasized the importance of supporting organizing by and with groups that do not fit within traditional identity paradigms or are particularly stigmatized in the current sociopolitical climate. As a Southern organizer asked rhetorically, "Does democracy serve the transgender woman in rural [America] anywhere? The answer is no. Unequivocally no." Similarly, a Western organizer commented that

> We must engage all communities, including immigrant and Native communities, to build political and economic power. [For example], there are ways to tie our work to business development. This requires us to think about personally mediated racism [as well as] internalized and institutional forms.

Many organizers discussed the challenges in organizing groups and communities that have been taught to distrust each other and to see themselves as "different" from groups that could, in fact, be useful allies. In the words of a Southern organizer, "People who don't live where we live, and love, to create [stereotypes] about us—for example, that we're always working in opposition to our own interests." As an organizer in the Northeast put it:

> Our urban and rural communities have intentionally been separated and divided and told that they hate each other to divide the power. So, there is a huge need right now, especially after what happened in the [2016] election, for bringing those communities together.

Organizers in all regions spoke about how the current divisive sociopolitical climate was fueling resentment, misunderstanding, and hatred between groups whose problems and issues—an economy that does not work for them, poor schools, unsafe neighborhoods, and lack of access to health care—might logically have brought them together. In discussing what would be needed to get past such divides and prejudices, organizers brought up the importance of recognizing that a "healthy democracy" is critical to building alliances across differences. They described a healthy democracy as a society in which "we're all free," kids have agency, "people have access to clean water and affordable food," and "everyone has an equal opportunity to participate in the governance and the decision making for the whole." For a Western organizer, this meant engaging rural African American and Latino parents "to understand that farming and the trauma around farming for *both* communities does not have to be the beginning and the end of that story."

The inclusion of particularly disenfranchised groups in a healthy democracy was described as intentionally including immigrants and refugees threatened with travel bans or deportation, and formerly incarcerated people of color. From staging demonstrations welcoming Muslims at U.S. airports during a travel ban, to helping mount ballot campaigns to end the lifetime disenfranchisement of former felons, such organizing strategies were a reminder of the critical link between civic participation, including grassroots organizing, not only to individual, family, and community health and well-being but also to the health of our democracy.

The Centrality of Organizing Led by Women of Color and Especially African American Women

Of the many forms of organizing shared, one of the most powerful and frequently discussed involved the strength and importance of women of color-led organizing. The role of the African American church also was emphasized—an institution long known as "a unit of identity, affirmation and solution" in African American communities (Eng, Hatch, & Callan, 1985), especially for women, and often a centerpiece of their organizing efforts (Airhihenbuwa & Liburd, 2006). Given the right opportunities and resources, the powerful

role women of color could play in helping build equity and a healthy democracy was widely articulated. As one organizer asked,

> How can we take the power that women of color have traditionally held in their communities and create a multiracial movement for inclusive democracy and use that as an umbrella for a host of issues we all care about, from immigration to criminal justice reform?

> And in another's words, The question is not "Are Black women *ready* to lead?" "The question is, '*is America ready to have us lead?*'"

Yet many organizers spoke, as well, of the challenges and pain often involved in women of color-led organizing—particularly when African American women were at the helm. As a Southern organizer remarked:

> Funders need to understand how important it is for minority-led groups to be . . . the spokesperson for their own issues. You need to stop bringing people who do not look like me to come to my community to do work on behalf of my people.

Another commented,

> As an African American woman, there have been doors that have been opened for me, not by me. A White person had to walk me in. . . . But once I got in, I was able to tell my Black truth. And that is, that every day is a struggle.

Finally, for many women of color, an often-ignored byproduct of community organizing was retraumatization, as organizers relive their own trauma while working with others. As a Midwestern organizer reflected,

> Is it [inadequate] money or is it the fact that we're dealing with so much trauma and oppression that we can't be successful in this work because we're not allowed to have the space to show up 100% fully?

But the organizers also discussed strategies for addressing trauma and retraumatization that differed substantially from the more traditional and individually focused therapeutic modes of care that remain the norm in the helping professions (Engel, 2017). Like Ginwright's (2010) notion of "radical healing," the organizers spoke of group and community-centered healing, noting that their very way of working promotes healing, since, "organizing is grounded in building relationships, building coalitions, and building power—all in the face of adversity and oppression."

Similarly, and while acknowledging that more traditional individual therapy can be useful for some organizers, participants suggested that they build into their practice the provision of time and resources needed for healing based on trauma-informed organizing and other community building (Wolf, Green, Nochaiski, Mendel, & Kusmaul, 2014) that is an essential part of the organizers' work.

Leveraging Public Health and "Using a Health Lens"

Many organizers spoke about the strategic value of partnering with public health departments and professionals and leveraging public health's expertise to gain credibility with stakeholders, while receiving their assistance with data collection and advocacy efforts. An environmental and labor organizer reported,

> We've partnered with [the Boston Public Health Commission] to have more of a public health frame and help to validate some of [our] demands. . . . In thinking about our next campaign [affordable child care] . . . we've actually brought in the [Commission] to be part of our coalition from the beginning.

Similarly, a Midwestern organizer noted that a "bright spot" of partnering with the Wisconsin Health Department was that "they bought into the whole health equity thing and then the deeper causes of [health and social inequities] that are way upstream . . . " He shared an example from an Indian reservation, in which a public health partnership and funder told him, "Just organize around whatever people care about and let's see what happens."

Organizers gave examples of how they sometimes reframed community concerns as health issues to gain visibility and action for change. But others also noted that while public health professionals often want to encourage collaboration between groups and communities, this should not include "forcing a marriage," or a strictly resource-driven relationship. As a Southern organizer explained, "Community groups and organizations often hear, 'We have money to give to you. But you have to [fund a coalition.]'" Others added that the very nature of community organizing is "from the bottom up," and where partnerships are mandated by public health stakeholders as a condition of support, that principle is disregarded.

The problem of unequal partnerships, which could be ended prematurely when no longer helpful to the partner with the most power, also was raised. As a Chicago organizer reflected on working with health care providers,

> . . . It's important to engage in organizing with [them] but making clear that we're not dating. . . . If we choose to partner with you in this effort, oh baby, we're married. And we are going to actually do this work together for the long haul.

Finally, organizers stressed the value of reframing problems in their communities as *health* problems to win support from decision makers and increase their own coalition's power by bringing in the public health community. As a Northeastern organizer explained, a health frame "changes the conversation" about working conditions because "when you're talking about mold or lead paint it's much harder for moralistic arguments about working harder to afford better [housing and health care] to make any sense." Whether convincing urban policy makers of the need for criminal justice reform and "a

progressive public health approach to drug policy," or helping residents and policy makers in a conservative rural area see the connection between fossil fuel extraction, climate change and health, framing problems and solutions in terms of their health impacts was described as a "pragmatic" organizing approach.

Discussion

This study had several limitations. The sample, while diverse across multiple dimensions, was not chosen using a research-driven sampling strategy but by leaders of facilitating organizations. This may well have biased attendance in favor of those most likely to speak out about race-based inequities and other social justice concerns, and thus the issues identified. Furthermore, the organizers were speaking in the context of a funder generated convening around health equity. This may have influenced their articulation of certain themes, since it was an opportunity to potentially correct what some organizers viewed as misguided priorities (e.g., a primary focus on health equity vs. equity more broadly). In other instances, including partnering with public health to address issues such as child care, organizers may have seen an opportunity to potentially broaden the agenda of health professionals. Finally, the nature of the data set, while enabling our analysis of hundreds of pages of transcripts from diverse regional convenings, precluded the asking of in-depth questions or the gathering more specific data from multiple sources, that could have enabled triangulation and enhanced research trustworthiness (O'Brien et al., 2014).

Despite these limitations, however, the data gave us a unique window into the concerns, achievements, strategies, and challenges faced by close to 140 community organizers, and their possible relevance for public health professionals' own equity-focused and community-partnered work. The candor with which the great majority of participants spoke, including their passionate and sometimes hard-to-hear articulation of their experiences and advice, further gave us confidence in the authenticity of what was shared.

Our first research question, "What strategies and practices in community organizing are being used to build power among marginalized groups and communities?" yielded a rich range of approaches. However, in addition to such practices as "just showing up" at community events, holding "listening tours" in rural and urban communities, providing leadership training and teaching a cycle of problem identification, planning, and advocacy for action, what also stood out was what we *didn't* hear. There was little discussion, for example, of whether or how the media, including social media, were used to bring attention to a local concern, and/or to community actions to help address such issues. Similarly, and while dynamic tensions and the use of conflict strategies are widely discussed in the literature (DeFilippis et al., 2010; Sen, 2003; Staples, 2012, 2016; Wolff et al., 2017), such approaches were rarely discussed (nor were intergroup or intragroup tensions much in evidence), during the multiday convenings. Such findings of omission underscore, again, the value of using multiple methods and data sources in helping provide missing or inadequate data and context, and more nuanced understandings of issues.

Data analysis concerning our second research question, "What challenges and barriers are organizers and their communities facing, particularly in the contemporary sociopolitical and cultural context?" clarified that for many organizers, those contextual issues were, *in and of themselves*, among the greatest obstacles to their organizing with already often vulnerable and disenfranchised communities. Whether with undocumented immigrants now more fearful of getting involved, or with the politics of divisiveness encouraging distrust and "othering" of the very groups with which many communities have shared economic and other concerns, the power of context was daunting.

Yet the contemporary sociopolitical and cultural environments also were seen as a spur to activism among many individuals and groups not previously engaged, in part *because* of the sense of urgency they created. Organizers spoke of the often unprecedented numbers turning out for marches and rallies for women's and immigrants' rights, collecting signatures for ballot initiatives for criminal justice reform, and so on, and showing up at hearings and in other venues to push for change. This surge in democratic activism also created some challenges, however, as when the sheer number of outsiders showing up at demonstrations and meetings organized by people of color was seen by some as potentially threatening hard-won local leadership.

Additional challenges, including the perceived chronic underfunding of organizations run by women of color, and the strings often attached to support for community organizations, for example, by a health department requiring creation of a coalition before any funding was provided also were described (Green, 2000). Finally, and while there was discussion of the dynamic tensions that frequently existed between helping communities find "winnable solutions" to their concerns and doing the longer term work needed to address systemic oppression, there was little open discussion of intragroup or intergroup tensions—a problem which also underscores the importance of multimethod data collection.

Many of the organizers' messages—for example, about effective strategies for building leadership and power in vulnerable communities; centering organizing led by women of color; and leveraging public health—appeared highly relevant to our final research question, "What community organizing practices can enhance current and emerging public health strategies to achieve health equity?" Yet other messages raised new or largely neglected challenges. First, and with the important exceptions, especially in the Northeast, of the opioid epidemic and health and mental health care access for immigrants and other disenfranchised groups, the major community issues identified by the organizers mass incarceration, voter suppression, and immigrant rights—while clearly important SDoH—were seldom seen as *health*

concerns in and of themselves. With 40% of the diversity in health outcomes in the United States linked to social and economic factors (Easterling & McDuffee, 2018) and with problems like underemployment or unemployment, food insecurity, unaffordable housing, and criminal injustice typically ranked above health and health care access among low-income Americans (J. Jones, 2017), public health professionals increasingly are broadening and deepening their view of what falls within the purview of improving the public's health (Iton & Shrimali, 2016; Krieger, 2017; Williams & Purdie-Vaughns, 2016). As the organizers in this study argued, making more central and visible public health's commitment to addressing racial and other systemic inequities in a wide range of programs and policies is critical to achieving equity writ large, of which health equity is only one part.

The extent to which issues of race and race-based power and privilege continue to shape the landscape in which public health is situated was perhaps the most powerful takeaway from this study. Consistent with a growing body of literature (Ford & Airhihenbuwa, 2010; Iton, & Shrimali, 2016; Williams & Medlock, 2017), a central message in all four regions was that working for health equity or a Culture of Health may be largely futile unless grounded in a deeper understanding of the ways in which our country's long and difficult history of structural racism, and the recent dramatic and alarming uptick in racial/ethnic "othering" and xenophobia, harm the public's health.

For close to two decades, public health scholar and leader Camara Jones' (2000) seminal work conceptualizing three levels of racism—internalized, personally mediated, and institutionalized—has been used in our field to help focus attention on the multiple ways that racism can be embodied in our persons and our policies. Building on such scholarship, and the concerns of the organizers in our study, we discuss in more detail elsewhere (Pearce, 2018), our recommendation that public health professionals study and apply critical race theory (CRT) as a relevant and often neglected part of the conceptual framework for this work (Ford, 2016; Ford & Airhihenbuwa, 2010; Gotanda, Peller, & Thomas, 1995; Obasogie, Headen, & Mujahid, 2017). As Ford and Airhihenbuwa (2010) note, with its strong grounding in social justice, CRT offers "tools for research and practice . . . to elucidate contemporary racial phenomena, expand the vocabulary with which to discuss complex racial concepts, and challenge racial hierarchies." Furthermore, in the words of Obasogie et al. (2017), applied to health equity, CRT also provides "a cross cutting process-based approach that lends itself as much to rethinking conceptual foundations as it does to facilitating on-the-ground action" (p. 324). Typically without using the language of CRT, community organizers and residents have long recognized the need for such perspective, and the deep cultural and historical oppressions that make such understanding so critical.

Finally, and particularly in the fraught contemporary context in which health educators and other public health professionals work, the utility of drawing on the knowledge and experience of community organizers cannot be overstressed. As Pearce (2018) notes, "Community organizers are in the business of building power and removing obstacles"—obstacles that must be overcome to achieve equity and health equity. With its emphasis on contextualizing health and social issues, building community power, leadership and control, and using these to address community-identified concerns, community organizing may offer important strategies and lessons for public health professionals both in our own organizations and efforts, and in more effectively partnering with communities toward the shared goal of improving equity.

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ORCID iD

Meredith Minkler https://orcid.org/0000-0002-7269-1221

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